



Department of  
**Mental Health &  
Substance Abuse Services**

**Office of Licensure**

Regional Offices

East Tennessee: Phone - (865) 594-6551 Fax - (844) 340-4482  
Middle Tennessee: Phone - (615) 532-6590 Fax - (615) 532-7856  
West Tennessee: Phone - (901) 543-7442 Fax - (844) 844-5538

**REPORTABLE INCIDENT FORM**

For use by TDMHSAS Licensed Facilities/Services

**\*\*\* PLEASE SEE PAGE 3 FOR INSTRUCTIONS ON COMPLETING THE REPORTABLE INCIDENT FORM \*\*\***

Date of This Report: 5/28/2018 Reporting Person: Cheryl Forrester  
Licensee: Milestones Title: Client Advocate  
Facility Phone Number: 615-789-6609 Phone Number: CA [REDACTED]  
Email Address: [REDACTED]  
Service Recipient: Anne Miller Gender: F D.O.B.: 2/19/1980 S.S. #: N/A  
Service Recipient: \_\_\_\_\_ Gender: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
Service Recipient: \_\_\_\_\_ Gender: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
Date/Time of Alleged/Suspected Incident: 5/28/2018 - 1:55 PM  
Location of Alleged/Suspected Incident: Front yard of Milestones  
Date/Time Incident Become Known to Staff: 5/28/2018 - 1:56 PM  
Staff Involved in Incident, if any: none  
(Staff S.S. #): N/A

Please  
contact  
Diana Nolen

with  
questions,

Detailed Description of Incident (If typing on this form, verify you are making it printer friendly - attach separate sheet if necessary): \_\_\_\_\_

Client was accidentally hit in the mouth with a plastic bat. Client was transported to Dickson ER with

MH-5375

RDA-2827

Nurse Marcia and Client Advocate Supervisor Caren  
Marvies. Client was examined and transferred to  
Skyline Medical Center.

Notifications by Licensee Already:

- |                          |                                 |             |             |
|--------------------------|---------------------------------|-------------|-------------|
| <input type="checkbox"/> | Adult Protective Services (APS) | Name: _____ | Date: _____ |
| <input type="checkbox"/> | Child Protective Services (CPS) | Name: _____ | Date: _____ |
| <input type="checkbox"/> | Department of Health (DOH)      | Name: _____ | Date: _____ |
| <input type="checkbox"/> | OTHER Agency: _____             | Name: _____ | Date: _____ |

**\*\*\* PLEASE SEE NEXT FEW PAGES ON INSTRUCTIONS FOR COMPLETING THE REPORTABLE  
INCIDENT FORM \*\*\***